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PROBLEMS IN THE CONTROL OF TUBERCULOSIS*

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The principles upon which health departments are founded and operate determine the interest and efforts of health officers and their staffs in tuberculosis control programs. Among the communicable diseases of known etiology, tuberculosis is the leading cause of death. This is true in almost all areas and jurisdictions despite declining tuberculosis mortality rates. It is true for California, where the decline in tuberculosis mortality rates for the State has been appreciable, from 90.8 in 1931, 71.4 in 1935, and 56.0 in 1940. Yet in 1945 there were 3,840 deaths assigned to tuberculosis, resulting in a provisional rate of 43 per 100,000 population.

Health departments have had the support of official and voluntary agencies and workers in tuberculosis control. The private physicians, the sanatoria, the tuberculosis associations, the social welfare departments, the rehabilitation workers have all contributed to the program. It is inconceivable to expect eradication of tuberculosis without their continued interest and efforts. In fact, eradication will call for heightened and extended effort by all these groups using present techniques as well as for the enlistment of workers with talents and methods not now being used.

Public health workers are interested in the eradication of tuberculosis, as soon as possible. They are increasingly conscious of the economic and social drains caused by the disease. They would like to see it reduced to a minor factor in mortality, like other communicable diseases such as smallpox and typhoid. They know, however, that in diseases of this nature the rate of decline, or increase, in morbidity and mortality is determined by the epidemiological characteristics of the disease, the make-up of the population in which it operates, and the control measures adopted. Not until one or more of these factors is altered in some way can there be anticipated a greater rate of decline.

Because control measures are the principal factor subject to alteration, they form the basis of this discussion. Accepted and established measures of control are mentioned because their new applications and expansions will be effective in speeding the rate of decline in mortality.

CASE-FINDING

The discovery of the case of tuberculosis is basic in control. The X-ray photofluorograph is the most recent addition to case-finding, making possible the X-ray examination of large numbers of people at a reasonable cost per case discovered. It has replaced to a large extent the tuberculin test in case-finding wherever the X-ray unit is available. It has enabled the shifting of emphasis to the adult group where the disease is more prevalent, the group which serves as the continuing reservoir of infection. It has discovered early and silent lesions, and chronic advanced lesions previously unknown to either the individual or to the health department or both. It has not eliminated the need for contact examination as conducted previously, although it can be used efficiently in the X-ray examination of contacts.

The effectiveness of the photofluorograph in case-finding must be gauged principally in terms of the portion of the total adult population examined by this means in a given period of time—a period of time in which new lesions will develop but which will not allow for widespread seeding of the uninfected examined population. Re-examination is necessary to consolidate the gains made by the first discoveries. This approach

* Presented at the Health Officers Section, League of California Cities, San Diego, September 18, 1946.

has been utilized in one Minnesota and two Georgia cities where an appreciable proportion of the adult population has responded to the intensive publicity, promotion, and solicitation necessary to get public action. In California the time is at hand to consider such an approach. In Sacramento, this is the aim of the present program. The equipment is available for other areas.

As part of the campaign to find tuberculosis, the American Hospital Association, the National Tuberculosis Association, and the U. S. Public Health Service have this month initiated a program to stimulate all hospitals to obtain chest X-ray examinations on admission for all patients. This program also encourages hospitals to provide facilities proper for the care of the tuberculous and for the protection of hospital personnel as well as other patients. It is well known that the policy of "No TB admissions" does not prevent a general hospital from accepting patients having other complaints, who are subsequently discovered to have tuberculosis.

TREATMENT

With respect to treatment of the cases discovered, advances have been made in medical practice. Any startling development in this field of control could very appreciably and rapidly affect the rate of decline in mortality. Present forms of treatment utilize improved applications of the basic principles of rest, adequate diet, and appropriate surgery. Refinements in the indications for and the skills involved in lobectomies and pneumonectomies have defined the place of these procedures in treatment. However, the long-awaited effective drug has not materialized at present. The dramatic effective sulfone derivative has not been found. Presently the most hopeful of the antibiotics is streptomycin which experimentally retards the development of tuberculosis in experimental animals and maintains status quo or slight improvement in man. The investigation of these continues. Present costs of streptomycin, because of small production plus restriction of distribution, are inhibiting factors in investigation.

HOSPITAL FACILITIES

Apparently then, there will be need for tuberculosis hospitals and sanatoria for some time to come. The number of beds available in relation to the number of persons needing hospitalization is still pertinent to the rate of decline in tuberculosis mortality. Adequate case-finding on an effective scale will broaden the gap existing in this relationship in many counties. The minimum standard ratio of beds to deaths is now established at 2.5. Excluding beds in Federal hospitals the ratio for California is 1.5 to 1. Since in California, sanatoria are operated by the counties, the ratios for the counties are pertinent. The extremes in this ratio are San Luis Obispo with 6.3 beds per death to Mendocino with 0.2 beds per death. Experience in other communities indicates that the 2.5 ratio does not satisfy the demands of an extensive case-finding program.

This lack of physical facilities, with shortages of professional personnel to staff such facilities, demands attention. Although additional sanatorium beds can be mobilized by the development and expansion of outpatient services for the home care of selected cases, this involves establishing clinics, either separate from or integrated with existing services for contact examination and post-sanatorium follow-up. Where this is done, some increase in public health nursing visits to tuberculous persons must be expected so that home supervision and education can be attained.

ISOLATION OF INFECTIOUS CASES

The function of the sanatorium in isolation is equally important to that of treatment. In light of the fact that 40 per cent of the discharges from some sanatoria are against medical advice, it can be seen that not always is this purpose served. Further, a varying proportion of these discharged patients have positive sputum. It is with these and with the patients refusing hospital care that the public health workers are most concerned.

In the event that there are sanatorium beds available and that it is determined that the services and care provided at the sanatoria are of satisfactory quality, a reasonable solution to the problem exists. California statutes empower health officers to preserve and protect the public health (Sec. 2559.5—Health and Safety Code). Tuberculosis is mentioned specifically, although exact procedures are not. A suggested manner of approach which would seem to be according to the intention of the law would be first to establish criteria for the communicability of the disease. These criteria must be met before considering an order for isolation, or for the release from isolation. A committee of the California Trudeau Society has considered laboratory criteria and suggests that:

> "The presence of tubercle bacilli on direct smear, or smear of the concentration, of a specimen obtained by free expectoration in the presence of an official observer, by pharyngeal swab, laryngeal swab, bronchoscopic aspiration, lung lavage, or stomach washing (which latter shall be confirmed by culture or animal inoculation) shall constitute evidence of communicability."

A suspected case may be ordered to have such an examination performed. For release, three negative specimens by concentrate were the suggested minimum.

If the case fits the established laboratory criteria, then a record of names, dates, laboratory findings, home conditions, and other pertinent data showing cause for action should be prepared.

The health officer then may issue an order for isolation, naming a reasonable area for isolation, such as a sanatorium. Law enforcement agencies may carry out such an order.

If there is an infraction of this isolation order, the patient may be brought before a court on charges of committing a misdemeanor. If guilty, and the court wishes, the man may be placed on probation, subject to compliance with the court's instructions.

Should it be deemed advisable, the patient may be confined in a room or ward at the sanatorium provided that he not be in undue danger in the event of fire or other emergency.

Such procedure demands the support of the public, the courts, and enforcement officers. Where it is being used, understanding has been gained. It might be said without doubt that the health officers reserve such action for those cases where all educational approaches to the patient are of no avail.

The reasons for patients leaving sanatoria against advice must be sought, studied, and corrected. The patient just returned from a sanatorium is the best booster or worst knocker that the sanatorium has. Patients do much to "sell" or "unsell" hospitalization. Therein lies part of the problem of isolation. Query of patients will reveal the defects as well as the good qualities of an institution. Discussion of these points with sanatorium administrators resulting in corrective action may lessen the need for compulsory isolation.

REHABILITATION OF PATIENTS

With respect to rehabilitation, the addition of more workers should be of great aid for this phase of the program. The physicians caring for the cases of tuberculosis must see that the rehabilitation workers learn of the persons ready for rehabilitation.

In the field of welfare should sickness disability be obtained in similar fashion to unemployment compensation, many economic problems would be lessened. Recognition of the patient as a unit of the family, the consideration of his social, economic, and mental welfare in terms of the family group is essential.

IMMUNIZATION

BCG vaccination merits mention in this discussion. While it is not a new subject, it is receiving much interest from tuberculosis workers at the present time. It is being used experimentally and also practically in control work. A few hospitals have adopted it as routine for nontuberculin sensitive nurses. It is being used on a large scale in Denmark, and in parts of Canada and South America. It has been used in certain localities in the United States. The favorable reports indicate that tuberculosis morbidity and mortality is reduced in the vaccinated to about one-fifth that of controls. Others report that while it has little or no effect, it does no harm. It is hoped that opinion will soon crystallize as to its efficacy and as to the groups in which it should be used.

CASE REGISTERS

Many health officers have recognized the essential character of the tuberculosis case register as an administrative guide. From these registers more definite information about the size and nature of the problem can be obtained. Likewise, the effectiveness of existing control measures can be accurately estimated and additional needs become apparent.

SUMMARY

This brief outline of tuberculosis control problems and programs indicates that present knowledge and methods of case-finding, treatment, and isolation are adequate to suppress rapidly the spread of the disease when they are broadly applied. More extensive use of what we know and have is indicated.

APPRENTICESHIPS AVAILABLE AT DIVISION OF LABORATORIES

The Division of Laboratories, State Department of Public Health, announces that apprenticeships are now available to technicians interested in public health laboratory work. The apprenticeships are for a six-month period and carry a stipend of $210 a month. Inasmuch as employment opportunities in public health laboratories are excellent, there is good assurance for placement following the apprenticeship period.

Further information regarding the apprenticeship training program or positions in public health laboratories may be obtained by writing to the Division of Laboratories, California State Department of Public Health, 3093 Life Sciences Building, Berkeley 4, California.

NATIONAL HEARING WEEK

To focus public attention on the National hearing problem, the National Hearing Society has set aside, and the President has endorsed, the week of November 10th-16th as National Hearing Week. The society seeks to create a National desire to eliminate this problem, which according to its estimates affects between 15,000,000 and 20,000,000 people in this country.

PARTICIPATION OF FULL-TIME LOCAL HEALTH DEPARTMENTS IN SCHOOL HEALTH PROGRAMS IN CALIFORNIA

III A. PHYSICAL EXAMINATION PROGRAM FOR SCHOOL CHILDREN*

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Physical examinations of school children have been a subject of discussion and controversy for many decades, and have undergone an interesting evolution.

> Originally planned as a means of detecting signs of communicable disease, they (school health examinations) were later used to discover untreated skin diseases and other conditions which might result in unnecessarily prolonged absence from school. Then came an emphasis on the discovery of physical defects, and at the present time emphasis is being placed on health examinations as educative experiences.[1]

There is rather widespread acceptance of the thesis that the school has responsibility for some evaluation of the health status of pupils.

> The provision of medical and dental examinations at regular intervals during the school career of each child constitutes a definite responsibility of school authorities. Physicians and dentists making such health inventories are employed either by the board of health or the board of education specifically for this purpose.[2]

Another statement of policy in this regard is the following:

> As a policy regarding health examinations, it is suggested that schools assume responsibility for developing a program of periodic health examinations, and that this program encourage examinations of pupils by their private physicians. In following such a policy, it will be necessary to provide examinations for large numbers of pupils whose parents can not or will not arrange examinations otherwise.[3]

Recent statements concerning school health examinations have been more on the purposes and nature of the examination than on the desirability of their provision. The purposes of school health examinations have been phrased by many authorities and groups. Running through most of these expressions is the stated conviction that the education of the child and of his parent concerning the desirability of good medical supervision and care is a primary objective of such examinations.

> The outstanding objective of the school medical inspection should be (to convince the parent of the importance of) the periodic examination on parental responsibility.[4]

The Committee on Professional Education of the American Public Health Association, in defining the functions of school physicians, states that one of their functions is the periodic medical examination of children, and continues:

> This is to demonstrate the value of health examinations, to give children the educational experience of learning how well they are, to evaluate growth and development, to reveal conditions which might adversely affect the health or educational progress of children, and to furnish recommendations for the care and alleviation of these conditions.[5]

OTHER TRENDS IN SCHOOL HEALTH EXAMINATIONS

Routine mass inspections of school children with their recurring records of uncorrected defects have been a source of comment, concern, and criticism by a large number of physicians, health departments, and schools.

> The present trend is to de-emphasize the annual periodic examination. In many cases, the time consumed by the annual repetition of the examination used all possible time available of medical, dental, nursing and teaching staff. Annually, defects of vision, hearing, teeth, tonsils, nutrition and personality were rediscovered, recorded and filed away. Lack of personnel has led to hasty, perfunctory, and inexpert examinations so that no effort could be made to sort out even those cases needing immediate medical care.[6]

To replace the annual examination of all pupils there has been a trend toward periodic examinations about once in every three years, supplemented by referrals of pupils with health problems who have been discovered by teachers and nurses. The Astoria Study went one step further and developed effective services for elementary school children on the basis of routine examinations for children entering school for the first time, supplemented by examinations of specially referred children only, in all other grades.

This decision was based on evidence that 80 per cent of the specially referred children from all grades

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* Third in a series of excerpts from a doctoral dissertation on file in Stanford University Library.

[1] Committee Report, *Suggested School Health Policies*, reprint *Hygeia*. Sept., Oct., and Nov. 1940. p. 21.

[2] Educational Policies Commission, *Social Services and the Schools*, National Education Association, Washington, 1939. p. 74.

[3] Committee Report, *Suggested School Health Policies*, op. cit. p. 22.

[4] Fred Moore, "Responsibilities of the Medical Profession in the Health Program of the Public Schools," *Journal of the American Medical Association*, XCIV, 1930, p. 1111.

[5] Committee on Professional Education, American Public Health Association, "Proposed Report on Educational Qualifications of School Physicians." p. 978.

[6] American Association of School Administrators, *Health in Schools*, National Education Association, Washington, 1942. p. 50.

exhibited important health problems in the eyes of physicians, whereas the corresponding proportion from all entering children without selection was but 40 per cent.[7]

The value of a health examination is partly determined by the amount of time which a physician has to devote to each child.

> A major criticism that has been leveled against school examinations generally is their superficiality. The hurried examination is regarded as wasteful. It overlooks facts, calls attention to conditions that are at the time not significant, and does not inspire respect for the procedure in the mind of either the child or his parent. This type of inspection ignores the previous history of the child which may have an extremely important bearing on the conclusion reached.[8]

If significant medical and educational purposes are to be achieved, the physician must have more time to spend with each child; and to utilize best his limited amount of participation in school health examinations it would seem desirable to have him spend his time on children with evident health problems—the specially referred group. As more medical time becomes available to schools, a worthy ideal would be to extend medical supervision to all children, whether in good or poor health, but at the present time, this seems an impossible task.

The examination conducted in the school can not be considered a complete and thorough inventory of the child, because the physician is acting without the benefit of the medical facilities of his private office or clinic. Spock writes:

> School health examinations make great contributions in detecting visual, auditory, and postural defects, in detecting occasional cases of skin and general diseases of a communicable nature. They act as a coarse strainer, picking up and bringing nearer to treatment such cases as the malnourished, the more obvious cardiacs, the severely anemic, the cases with visible abnormalities of the nose and throat and obvious tooth decay. They are easily capable of missing the milder cases of diabetes, urinary tract disease, anemia, tuberculosis and so forth, that depend on specific tests. However, unless they are supplemented with good histories they ignore the truly vital aspects of the child's emotional and physical functioning.[9]

There is almost universal agreement on the concept that although the school has the responsibility of making provision for the inventory of the health status of children and recommendations for care, detailed diagnosis is the province of the private physician, and that the home or an appropriate social agency other than the school is responsible for the administration of medical service and care.

> While school authorities are directly concerned with the health needs of every child, medical care is a medical service, and as such, lies outside the responsibility of the public schools.[10]

In order that the defects of children will be more likely to be corrected, emphasis is being placed on the necessity of having the parent present at the school examination of the elementary school child. In the Walker and Randolph study the following conclusion was reached:

> There is ample evidence of the importance of having the parent present at the time of physical examination. The study, however, indicates that it is more important for young children than at older ages . . . The correction of vision, dental and tonsil defects among six- and sexen-year-old children is shown . . . to be higher if a parent is present at the examination.[11]

In the Astoria School Health Study a similar conclusion was reached.

> New insistence was placed on having the parent present at the examination . . . One of the principal values from having the parent present at the examination is to give her a real understanding of the importance of the child's health problems and thus to create a firm resolve to follow out the recommendations made . . . Prompt and determined action by the parent means the elimination of one, two, three, or, in some cases, even a dozen visits of the nurse to the home just to urge and prod parents to an action which ought to result spontaneously from the examination experience alone.[12]

Medical examinations for the high school student as well as for the younger child are important in an adequate school health service, but have received less attention from schools and health departments.

> The problems of the adolescent child need more consideration than they ordinarily receive. At this age the specialized training of doctor and nurse will be useful not only in the field of examination and advice but in more specific teaching.[13]

The educational purposes of the health examination in high schools are directed to the student rather than to his parents, although conferences with parents may be necessary at a later time. The adolescent is rapidly developing independence of parental control and often

[7] Dorothy Nyswander, *Solving School Health Problems*, The Commonwealth Fund, New York, 1942. pp. 294-295.
[8] Ibid, pp. 295-296.
[9] Benjamin Spock, "After the School Examination, What?", *Progressive Education* XVII, January, 1940. p. 50.
[10] Educational Policies Commission, *Social Services and the Schools*, op. cit. p. 77.
[11] W. Frank Walker and Carolina R. Randolph, *School Health Services*, The Commonwealth Fund, New York, 1941. p. 148.
[12] Nyswander, *Solving School Health Problems*, op. cit., p. 301.
[13] Walker and Randolph, *School Health Services*, op. cit., p. 162.

resents the presence of his parent at the examination. Further than this, it is desirable to develop in young people, responsibility for their own health care and behavior, and the examination may be utilized for this purpose if the contact between physician and pupil is direct.

Summarizing findings and convictions of various groups, the trend today is toward school health examinations (1) which educate the child concerning his health needs and problems, (2) which educate his parents similarly, and which lead them to seek good medical supervision and care, (3) which are leisurely enough to permit more complete health inventories of children, (4) which utilize the health history of the child, and (5) which devote more time to the children who are in greatest need of health supervision and care.

NOTE.—The second portion of installment III will be printed in the next issue.

STATE REGULATIONS FOR CONTROL OF INFANT DIARRHEA

Since July, outbreaks of diarrhea of the newborn occurring in five hospitals have been reported to the State Department of Public Health. In only one hospital were any cases reported prior to the death of one or more infants. In this one hospital, prompt recognition and resolute administrative action prevented spread of the condition and no deaths occurred.

Recognizing the seriousness of diarrhea of the newborn as a communicable disease, the State Board of Public Health has adopted the following regulations regarding reporting this disease, isolation of cases, and quarantine (Section 2564, Administrative Code):

(a) **The definition** of a reportable case of diarrhea of the newborn shall be as follows:

Diarrhea of the newborn up to three weeks of age occurring in a hospital giving maternity service. Diarrhea of the newborn, regardless of etiology, shall be suspected to exist when an infant has more than one liquid stool in 24 hours and shall be considered definitely present if this persists for more than two days. An exception may be made in the case of entirely breastfed infants who show no sign of illness and are gaining weight.

(b) **Isolation of Case.** The infant suspected of diarrhea shall be placed in strict isolation until discharged from the hospital, and the case shall be reported immediately by telephone to the local health officer.

(c) **Quarantine of Nursery.** If two or more cases occur, the nursery shall be quarantined and no newborn infants shall be admitted until all exposed infants have been discharged and the nursery thoroughly cleaned.

Epidemic diarrhea has been recognized for a number of years and in some instances these epidemics have occurred during outbreaks of diarrhea and nausea of unknown cause among adults, or in areas where influenza was concurrently epidemic. Hospital screening and isolation of mothers with histories of diarrhea or of respiratory infection and barring all staff with these conditions from nursery service are important measures in the prevention of epidemic diarrhea among the newborn.

CONTROL IN HOSPITALS

Procedures recommended by the State Department of Public Health for the control of diarrhea of the newborn in hospitals and maternity homes include:

1. An auxiliary clean newborn nursery should be established for new admissions separate and apart from the regular nursery.
2. Separate nursery equipment as well as nursing service must be provided in:
   (a) Isolation nursery with infected infants.
   (b) Suspect nursery where infants have been exposed.
   (c) Clean nursery.
3. Careful check should be made of all techniques including nursing, formula preparation and refrigeration, feeding and hand washing to determine if a break in technique has occurred which might be responsible for the outbreak.
4. Check all attendants entering delivery room, formula room and nursery for presence of any type of infection.
5. All equipment of maternity service should be inspected for possible defects.
6. No newborn infants should be admitted to the regular nursery until all exposed and isolated cases have been dismissed and the nursery thoroughly cleaned. At least 24 hours should elapse between the dismissal of the last baby and any new admission during which time the walls and floors of the nursery must be thoroughly scrubbed with soap and water, a maximum of air and sunlight admitted and all equipment coming in contact with infants thoroughly cleansed and exposed to direct sunlight or ultraviolet light for a period of at least 6 hours.
7. In the event new cases of diarrhea appear in the clean nursery the entire maternity division should be closed until all patients and contacts are dismissed and all rooms and equipment thoroughly cleaned.

The regulations stipulating action which must be taken in maternity hospitals and homes are contained in the Maternity Hospital Regulations:

Any infant suspected of developing or showing symptoms of diarrhea shall be immediately placed

in the suspect nursery or isolation nursery and cared for with strict isolation technique. Infant contacts shall be kept under close observation until discharged from the hospital. Infants transferred from the newborn nursery to the suspect or isolation nursery shall remain therein until discharged from the hospital.

Where there are two or more cases of diarrhea of the newborn no new infants shall be admitted to such nursery and an auxiliary emergency newborn nursery be provided. After emptying the infected nursery, it shall be thoroughly cleaned with an approved technique before re-admitting infants.

Any occurrence, such as epidemic outbreaks, poisonings or other unusual occurrences, which threatens the welfare, safety, or health of any patient admitted to any of the institutions covered by the Hospital License Law, or the rules and regulations pertaining thereto, shall be immediately reported, either by telephone or telegram to the local health officer. The institution shall furnish such other pertinent information related to such occurrences as the local or State Department of Public Health may require. . . .

All cases of diarrheal disorders, regardless of etiology, with symptoms described under Definitions, shall be reported immediately by telephone to the local health officer so that steps can be taken to set up control measures before a potentially serious infection has spread through the nursery.

The State Department of Public Health has two hospital nursing consultants who are available upon request to assist hospitals in working out procedures for the prevention and control of diarrhea of the newborn.

In new constructions, maternity departments of 10 or more beds are required under State licensing regulations to include, in addition to the regular and isolation nurseries, a "suspect" nursery for infants exposed to or suspected of developing infections. It is advisable, where possible, that existing facilities make similar provisions.

AGREEMENT ON VENEREAL DISEASE CONTROL MEASURES

For the nation-wide peacetime control of venereal diseases, an Eight Point Agreement was entered into earlier this year by the Army, Navy, Coast Guard, the Federal Security Agency and the Association of State and Territorial Health Officers. The agreement, which replaces a similar document drawn up in 1940, follows:

It is recognized that the following services should be developed by State and local health and police authorities in cooperation with the U. S. Public Health Service and the Social Protection Division of the Federal Security Agency, the U. S. Treasury Department, the U. S. Army, the U. S. Navy and interested voluntary organizations:

(1) Early diagnosis and adequate treatment by the Army, Navy and Coast Guard of military personnel infected with venereal diseases.

(2) Health departments will assure the adequacy of case finding, diagnostic treatment and case holding procedures for the civilian population.

(3) When authentic information can be obtained as to the probable source of venereal disease infection of military personnel, the facts will be reported by officers of the Army, Navy [1] or Coast Guard to State or local health authorities. If additional authentic information is available as to contacts had by infected military personnel during the communicable stage, this should also be reported.

(4) All contacts of military personnel with infected civilians should be reported to appropriate officers of the Army, Navy or Coast Guard by local or State Health Officers.

(5) Recalcitrant infected persons with venereal diseases should be forcibly isolated during the period of communicability. In civilian populations it is a duty of local health authorities to obtain any needed assistance of the local police authorities in enforcing such isolation.

(6) Opportunities for contacts with persons reasonably suspected of being infected with venereal disease should be decreased as far as possible. The local police department is responsible for the repression of commercialized and clandestine prostitution. The local health departments, the State health departments, the U. S. Public Health Service, the Social Protection Division, the Army, Navy, and the Coast Guard will cooperate with local police authorities in repressing prostitution. Local police departments should be provided with such information relative to places of procurement, and exposure, as is necessary to carrying out their responsibilities.

(7) An aggressive continuous program of education should be carried on both among military personnel and the civilian population regarding the dangers of venereal diseases, methods of preventing venereal infections, and the steps which should be taken if a person suspects that he is infected.

(8) State and Territorial health officers, the Federal Security Agency, the Treasury Department, the Army and Navy all desire the assistance of representatives of the American Social Hygiene Association or affiliated social hygiene societies or other voluntary welfare organizations or groups in developing and stimulating public support for the above measures.

The full text of working relationships recognized as essential in carrying out the Agreement appears under the title, "Peacetime Relationships in Venereal Disease Control," *Journal of Social Hygiene*, June, 1946.

[1] Familial contacts with naval patients will not be reported.

FELONY CHARGES FOR CONSPIRACY TO VIOLATE HEALTH LAWS

Acting on information supplied by the State Bureau of Food and Drug Inspections, the San Francisco Municipal Court has issued complaints charging five individuals with the felony of conspiring to divert to retail food channels candy condemned as unfit for human consumption.

Involved is a portion of 13,420 tons of candy and cookies collected from Army stores in the Pacific. Upon its arrival at the Army base in Oakland, it was discovered that the entire lot had become worm infested, moldy and had otherwise deteriorated with time and tropic heat. The candy and cookies were condemned by the Army and were sold to a salvage firm under a contract which stipulated that they were to be denatured with fish oil and sold for animal food.

The State Department of Public Health first learned of the transaction when a representative of a candy manufacturer inquired how inferior candy bearing the brand name of the firm had reached the market. Although prompt action in seizing the candy in warehouses prevented a large portion of it from reaching the public, inspectors found some of the lot being sold in retail stores in San Francisco, Oakland, and Los Angeles and in vending machines in theater lobbies in San Francisco.

The entire lot was originally sold to the salvage company for about $8,000. It is estimated that the portion which reached retail outlets rose in price during resales to more than $75,000. Only the cookies are known to have been converted into animal food.

Not only is the public defrauded by such a conspiracy but the reputation of reliable firms is endangered since a large portion of the confectionary was in candy bars and packages bearing brand names.

The U. S. Food and Drug Administration, the Army Intelligence Service and the Federal Bureau of Investigation assisted in the investigations.

CIVIL SERVICE EXAMINATIONS

The State Personnel Board announces a civil service examination for assistant industrial hygiene engineer. The final date for filing application is November 16; the examination date is December 7.

"The total hidden costs of sickness and disability—wage loss to workers and costs to business—totaled in 1943 not less than 15 billion dollars—fully one-tenth of the total income payments to individuals in the United States in the average war years . . . ."—*The Health of the Nation,* Federal Security Agency, Washington, D. C.

HEALTH OFFICER CHANGES

E. H. Benson, M.D., has replaced John L. Parker, M.D., as health officer of Imperial County.

Espie B. Bramlett, M.D., has replaced Charles F. Keith, M.D., as health officer of Colusa County.

V. J. Collins, D.O., has replaced Mr. R. A. Saeltzer, as health officer of the City of Redding, Shasta County.

MORBIDITY REPORT—SEPTEMBER, 1946

CIVILIAN CASES

Reportable diseases	Week ending				Total cases	5-yr. median	Total cases
	9/7	9/14	9/21	9/28	Sept.	Sept.	Jan.-Sept. inc.
Amebiasis (amoebic dysentery)	3	1	4	3	11	.....	129
Anthrax	.....	.....	.....	.....	.....	.....	1
Botulism	.....	.....	.....	.....	.....	.....	1
Chancroid	8	24	18	8	58	.....	928
Chickenpox (varicella)	55	70	56	85	266	358	20,783
Cholera, aisatic	.....	.....	.....	.....	.....	.....	.....
Coccidioidal granuloma	1	1	.....	2	4	.....	24
Conjunctivitis—acute infectious of the newborn (ophthalmia neonatorum)	.....	1	7	2	10	.....	43
Dengue	.....	.....	.....	.....	.....	.....	.....
Diphtheria	23	19	26	17	85	67	903
Dysentery, bacillary	2	1	13	3	19	.....	187
Encephalitis, infectious	2	10	4	6	22	.....	120
Diarrhea of the newborn	.....	1	1	1	3	.....	35
Epilepsy	9	46	19	46	120	.....	1,117
Food poisoning	.....	.....	.....	.....	.....	.....	261
German measles (rubella)	16	32	20	29	97	.....	11,671
Glanders	.....	.....	.....	.....	.....	.....	.....
Gonococcus infection	777	1,138	1,453	782	4,150	1,556	28,679
Granuloma inguinale	.....	1	3	1	5	.....	37
Influenza, epidemic	1	3	2	5	11	41	5,302
Jaundice, infectious	2	5	3	5	15	.....	147
Leprosy	.....	.....	.....	.....	.....	.....	.....
Lymphogranuloma venereum (lymphopathia venereum, lymphogranuloma inguinale)	1	7	5	4	17	.....	158
Malaria	4	4	11	7	26	16	310
Measles (rubeola)	42	45	39	43	169	274	61,594
Meningitis, meningococcic	6	5	5	7	23	38	441
Mumps (parotitis)	71	78	70	80	299	741	17,183
Paratyphoid fever, A and B	4	.....	.....	4	8	.....	87
Plague	.....	.....	.....	.....	.....	.....	.....
Pneumonia, infectious	15	20	22	20	77	175	1,701
Poliomyelitis, acute anterior	162	151	123	129	565	67	1,679
Psittacosis	.....	.....	.....	.....	.....	.....	3
Rabies, human	.....	.....	.....	.....	.....	.....	.....
Rabies, animal	7	.....	2	8	17	48	336
Relapsing fever	.....	.....	1	.....	1	.....	5
Rheumatic fever	8	14	19	15	56	.....	329
Rocky Mountain spotted fever	.....	.....	.....	.....	.....	.....	1
Scarlet fever	41	84	61	77	263	318	5,704
Septic sore throat, epidemic	1	10	4	3	18	.....	30
Smallpox (variola)	.....	.....	.....	.....	.....	0	3
Syphilis	533	865	1,207	577	3,182	1,985	19,233
Tetanus	2	4	1	3	10	.....	69
Trachoma	1	.....	.....	.....	1	.....	25
Trichinosis	1	1	1	1	4	.....	19
Tuberculosis, pulmonary	150	151	202	256	759	648	8,466
Tuberculosis, other forms	8	11	6	26	51	43	404
Tularemia	.....	.....	2	.....	2	.....	6
Typhoid fever	5	2	5	3	15	24	112
Typhus fever	1	2	.....	4	7	.....	44
Undulant fever (brucellosis)	4	8	9	2	23	23	223
Whooping cough (pertussis)	44	80	92	75	261	707	3,260
Yellow fever	.....	.....	.....	.....	.....	.....	.....
					10,730	.....	185,379

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